Exhibit “E”

ECFMG | EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

3624 Market Street
Philadelphia PA 19104-2685 USA
215-386-5900 | 215-966-3124 Fax
www.ecfmg.org

REQUEST FOR FMLA LEAVE OF ABSENCE

Complete the form and return it to Human Resources.

Name Artis Ellis Department CSEC – Houston

Job Title Center Manager Phone Extension (281) 260-7400 X-7226

I require a Leave of Absence due to the following reasons: (Check one)

____ Birth and care of my child or placement for Adoption/Foster Care of Child

X Serious Health Condition that makes me unable to perform the essential functions of my job.

____ Serious Health Condition affecting my ☐ spouse, ☐ child, ☐ parent, for which I need to provide care.

Please describe Major Tumor removed from the Brain

I need this Leave of Absence to begin on 9/12/12 (Date) and I expect to return on or about 10/22/12 (Date)

I realize that I will need to provide Medical Certification from my health care provider for reasons of my Serious Health Condition or that of a spouse, child or parent I will be caring for.

I understand that I will be informed in writing as to whether my request for Family Medical Leave of Absence has been approved. I will be required to utilize all available, applicable paid time off while I am out on this leave. I also understand that the FMLA leave can last no longer than twelve (12) weeks. Should I need time beyond the allotted FMLA leave, I will request a non-FMLA leave based on the ECFMG® policy.

Requestor's Signature Artis Ellis Date 10/2/12

Human Resources Signature Shawn Arnold-Ross Date 10/3/2012

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EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES

PHILADELPHIA OFFICE

3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104-2685, U.S.A.

TELEPHONE: 215-386-5900 • FAX: 215-222-9363 • CABLE: EDCOUNCIL, PHA.

REQUEST FOR SHORT TERM DISABILITY (STD)

Complete the form and return it to Human Resources.

Name Artis Ellis Department CSEC- Houston

Job Title Center Manager Phone Extension (281) 260-7400 X 7226

ECFMG STD is a benefit that all regular full time employees are eligible for, after 90 days of employment, with an approved disability claim. STD benefits are paid out from Sun Life Assurance Company, not through ECFMG payroll. An STD claim packet must be completed by the employee and healthcare provider and returned to Human Resources for review/processing. An STD benefit claim approval is not guaranteed; the information provided must be reviewed and approved by the underwriting department at Sun Life Assurance Company. The benefit has a two (2) week-unpaid waiting period during which any available sick time, vacation time or optional holiday time must be used. After the two week waiting period, if the claim is approved, a benefit of 80% of the weekly salary will be paid as the benefit. All employees have the option of supplementing the STD benefit with any accrued/remaining sick, vacation or optional holiday time up to the full amount of the base net weekly pay until all available time is exhausted. Sun Life Assurance Company will provide written claim approval/denial for the employee.

I understand the above information regarding an ECFMG STD benefit claim and authorize the following choice for my STD benefit claim:

✓ I agree to have ECFMG supplement my 80% STD with any/all of the available benefit time indicated below for each pay period of my disability, until exhausted.

- ☐ Sick,
- ☐ Vacation and/or
- ☐ Optional Holiday time

____ I DO NOT wish to supplement my 80% STD claim with any available sick, vacation or optional holiday time. Any current time will remain available when I return from STD.

Employee's Signature Artis Ellis Date 10/2/12

Human Resources Signature Sharon Smallwood-Kim Date 10/3/2012

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10/02/2012 12:32PM (GMT-04:00)

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 2/28/2015

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: Artis Ellis

Employee's job title: Center Manager Regular work schedule: 7-3:30pm

Employee's essential job functions: _____

Check if job description is attached: X

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: Artis (First) Ellis (Last)

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: Daniel Yoshor 1709 Dryden Houston TX 77030

Type of practice / Medical specialty: Neurosurgery

Telephone: (713) 798 4696 Fax: (713) 798 3739

PART A - MEDICAL FACTS

1. Approximate date condition commenced: unknown

Probable duration of condition: unknown

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
___No X Yes. If so, dates of admission:

9/12/12 St. Lukes Episcopal Hospital Houston TX 77030

Date(s) you treated the patient for condition:

9/14/12 -

Will the patient need to have treatment visits at least twice per year due to the condition? X No ___ Yes.

Was medication, other than over-the-counter medication, prescribed? X No ___ Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
X No ___ Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? X No ___ Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section 1 to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: ___ No X Yes.

If so, identify the job functions the employee is unable to perform:

Need to stay out 4-6 weeks to recover from surgery

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

Patient underwent transsphenoidal resection of Pituitary macroadenoma on 9/14/12 - she would need 4-6 weeks to recover from surgery.

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No X Yes.

If so, estimate the beginning and ending dates for the period of incapacity: 9/12/12 — 10/22/12

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? X No ___Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?
___No ___Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

_____

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? X No ___Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?
___ No ___Yes. If so, explain:

_____

_____

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

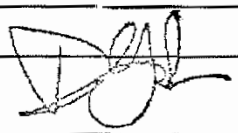
_____

_____

_____

_____

_____



Signature of Health Care Provider

Date 9/25/12

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Designation Notice (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

OMB Control Number: 1215-0181
Expires: 12/31/2011

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form H-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: Artis Ellis

Date: October 2, 2012

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on October 2, 2012 and decided:

__X__ **Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

__X__ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: September 12, 2012 to October 22, 2012.

_____ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

_____ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

__X__ We are requiring you to substitute or use paid leave during your FMLA leave.

__X__ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ____ **is** ____ **is not** attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

_____ **Additional information is needed to determine if your FMLA leave request can be approved:**

_____ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____ (Provide at least seven calendar days), unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

_____
(Specify information needed to make the certification complete and sufficient)

_____

_____ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

_____ Your FMLA Leave request is Not Approved.

_____ The FMLA does not apply to your leave request.

_____ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 -- 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

Form WH-382 January 200

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3624 Market Street
Philadelphia PA 19104-2685 USA
215-386-5900 215-386-3124 Fax
www.ecfmg.org

Fitness for Duty
(Authorization to Return from Medical Leave.)

Employee Name: Artis Ellis Job Title: Center Manager

Physician Name: Dr. Tom M. Thom

MANAGER:
Highlight all essential functions of the job on a copy of the employee's JD and attach to this form for the employee to provide his/her physician. Be sure to review areas such as Job Summary, Physical Demands, Work Environment, Skills and Abilities and Duties and Responsibilities.

MUST BE COMPLETED BY PHYSICIAN:

1. Is employee able to perform the essential functions of the position as highlighted on the attached job description with or without an accommodation? (Answer the question only after reviewing the attached job description and discussing with the employee/patient.) Check Yes or No:

Yes	No
☑	☐

2. Date the employee is able to return and perform all job functions:

10/22/2012

3. If an accommodation is needed for an ADA covered disability, please indicate suggestions for the type of accommodation that would enable the employee to perform the essential functions of his/her job:

Signature of Employee: Artis Ellis Date: 10/14/12

Signature of Physician: [signature] Date: 10/16/2012

Type of Practice (Field of Specialization, if any): Endocrinology

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FOREIGN MEDICAL GRADUATES

3624 Market Street
Philadelphia PA 19104-2685 USA
215-823-2289 | 215-966-3124 Fax
www.ecfmg.org

Via – Fed-ex tracking # 8009 7706 9787

October 19, 2012

Artis Ellis
3915 Oakside Drive
Houston, TX 77053

Dear Artis,

As you are aware, the Federal Medical Leave Act (FMLA) provides up to twelve weeks of an unpaid leave in a twelve-month period, and continuation of health benefits under certain circumstances. Your current approved FMLA leave began back on September 12, 2012 until October 19, 2012. We have received your Fit for Duty form completed by your physician; releasing you to return to work at full capacity as of October 22, 2012.

You previously used FMLA beginning January 18, 2012 until January 30, 2012, to care for your spouse. You currently have 4 weeks and 6 days of FMLA remaining in this 12 month period. If you have the need for additional FMLA time, please contact me.

Feel free to contact me if you have any questions.

Sincerely,

Sharon Trowell-Roman
HR Manager

Cc: File ✓

FedEx Express **NEW** Package US Airbill

FedEx Tracking Number 8009 7706 9787

Form ID No. 0200 — Sender's Copy

1 From *Please print and press hard.*

Date 10/19/12 Sender's FedEx Account Number 019130595

Sender's Name Helen Ann Coin Phone (215) 823-2134

Company ECFMG

Address 3624 Market St. Dept./Floor/Suite/Room

City Philadelphia State PA ZIP 19104

2 Your Internal Billing Reference First 24 characters will appear on invoice. OPTIONAL

3 To

Recipient's Name Artis Ellis Phone (713) 434-7702

Company

Address 3915 Oakside Dr. Dept./Floor/Suite/Room

We cannot deliver to P.O. boxes or P.O. ZIP codes.

Address

Use this line for the HOLD location address or for continuation of your shipping address.

City Houston State TX ZIP 77053

☐ HOLD Weekday FedEx location address REQUIRED. NOT available for FedEx First Overnight.

☐ HOLD Saturday FedEx location address REQUIRED. Available ONLY for FedEx Priority Overnight and FedEx 2Day to select locations.

Easy new Peel-and-Stick airbill. No pouch needed.
Apply airbill directly to your package. See directions on back.

4 Express Package Service * To most locations.

NOTE: Service order has changed. Please select carefully.

Packages up to 150 lbs. For packages over 150 lbs., use the new FedEx Express Freight US Airbill.

Next Business Day	2 or 3 Business Days
☒ FedEx First Overnight — Earliest next business morning delivery to select locations. Friday shipments will be delivered on Monday unless SATURDAY Delivery is selected.	☐ FedEx 2Day A.M. — Second business morning.* Saturday Delivery NOT available.
☐ FedEx Priority Overnight — Next business morning.* Friday shipments will be delivered on Monday unless SATURDAY Delivery is selected.	☐ FedEx 2Day — Second business afternoon.* Thursday shipments will be delivered on Monday unless SATURDAY Delivery is selected.
☐ FedEx Standard Overnight — Next business afternoon.* Saturday Delivery NOT available.	☐ FedEx Express Saver — Third business day.* Saturday Delivery NOT available.

5 Packaging * Declared value limit $500.

☒ FedEx Envelope* ☐ FedEx Pak* ☐ FedEx Box ☐ FedEx Tube ☐ Other

6 Special Handling and Delivery Signature Options

☐ SATURDAY Delivery NOT available for FedEx Standard Overnight, FedEx 2Day A.M., or FedEx Express Saver.

☒ No Signature Required — Package may be left without obtaining a signature for delivery.

☐ Direct Signature — Someone at recipient's address may sign for delivery. *Fee applies.*

☐ Indirect Signature — If no one is available at recipient's address, someone at a neighboring address may sign for delivery. For residential deliveries only. *Fee applies.*

Does this shipment contain dangerous goods? One box must be checked.

☒ No ☐ Yes As per attached Shipper's Declaration. ☐ Yes Shipper's Declaration not required. ☐ Dry Ice Dry Ice, 9, UN 1845 ____ x ____ kg

Dangerous goods (including dry ice) cannot be shipped in FedEx packaging or placed in a FedEx Express Drop Box. ☐ Cargo Aircraft Only

7 Payment *Bill to:* Enter FedEx Acct. No. or Credit Card No. below.

☒ Sender Acct. No. in Section 1 will be billed. ☐ Recipient ☐ Third Party ☐ Credit Card ☐ Cash/Check

FedEx Acct. No. / Credit Card No. Exp. Date

Total Packages	Total Weight	Total Declared Value†
	lbs.	$ .00

†Our liability is limited to US$100 unless you declare a higher value. See back for details. By using this Airbill you agree to the service conditions on the back of this Airbill and in the current FedEx Service Guide, including terms that limit our liability.

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